Notification of Change of Covered Dependents (Removal)

*Please attach the Certificate Eligibility Card.

常務理事	事務長		担　当

Insured person's code and number		Name of the insured person	Furigana	Date of birth (Y) (M) (D)	Gender: Male / Female	Date of acquisition of eligibility (Y) (M) (D)
Address of the insured person	〒		Telephone ( )		Standard monthly remuneration	,000 yen (in thousands of yen)

Type of change	Name of dependent	Date of birth	Gender	Relation ship	Occupation or year in school	Annual expected income (including tax)	Household	Date individual was no longer a dependent	Reason	Remarks
Reduction	Furigana (Last name) (First name)	(Y) (M) (D)	M F			yen	Living together Living separately	(Y) (M) (D)		
Reduction	Furigana (Last name) (First name)	(Y) (M) (D)	M F			yen	Living together Living separately	(Y) (M) (D)		
Reduction	Furigana (Last name) (First name)	(Y) (M) (D)	M F			yen	Living together Living separately	(Y) (M) (D)		
Reduction	Furigana (Last name) (First name)	(Y) (M) (D)	M F			yen	Living together Living separately	(Y) (M) (D)		
Reduction	Furigana (Last name) (First name)	(Y) (M) (D)	M F			yen	Living together Living separately	(Y) (M) (D)		

*Please indicate if you would like issuance of losing qualification in the Remarks section.

事業主の確認	
事業所所在地	
事業所名称	
事業主氏名	
電話	

◎ To remove a dependent due to the start of employment insurance, please attach a copy of the employment insurance benefit qualification certificate which lists the start date for receiving employment insurance.

社会保険労務士の提出代行記載欄

Date of submission (Y) (M) (D)

受付日付印

To the Western Digital Technologies Health Insurance Association